Testimony of
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on
Community Health Centers

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Chairman Whitfield, Congressman Stupak, thank you for inviting me to testify on the role of the Medicaid program in serving millions of Americans who seek care through community health centers (CHCs). CHCs are an important part of America's health care safety net, providing comprehensive primary and preventive health care services to all who seek care. They serve in rural areas or in inner-city neighborhoods, places where too many people do not have the access to the quality health care they require. CHCs exist in areas where economic, geographic, or cultural barriers limit access to primary health care for a substantial portion of the population; and, they tailor services to the needs of the community. Services include primary and preventive health care, prenatal services, dental care, and essential ancillary services such as laboratory tests, X-ray, environmental health, and pharmacy services. In addition, they provide services such as outreach and health education, transportation, and translation services.

CHCs, State Medicaid Programs, and Medicare Serve Americans with Limited Incomes

The majority of Medicare and Medicaid dollars that go into CHCs are through the Federally Qualified Health Centers (FQHCs). Congress established the FQHC program in 1989 to respond to concerns that health centers were using grant funds intended to support care for the uninsured to supplement Medicare and Medicaid payments. FQHCs under Medicare and Medicaid include three types of centers:

- Community health centers that receive grants under section 330 of the Public Health Service Act;

- FQHC "look-alikes" – centers that meet all of requirements for a community health center under section 330 of the Public Health Service Act, but do not receive such a grant, and that are not owned, controlled or operated by another entity; and
- Outpatient health programs or tribal facilities operated by a tribe or tribal facility under the Indian Self-Determination Act or by an urban Indian organization receiving funds under Title V of the Indian Health Care Improvement Act for the provision of primary health services.

Over the years, Medicaid spending through FQHCs has increased substantially. As recently as 1991, Federal Medicaid spending on services provided to Medicaid beneficiaries by FQHCs totaled $45 million. Federal Medicaid expenditures in FQHCs have increased since then to $778 million in FY 2004. This increased spending is due in large part to an increase of about 500 new health center sites under the President's health center initiative. (These figures do not include expenditures through managed care contracts or the state share of Medicaid funding). Total Federal and State Medicaid spending total $1.3 billion in FY 2004.

According to HRSA, Medicaid is the largest single source of revenue for the FQHCs. Medicaid accounts for 36 percent of total revenue of the FQHCs.

CMS designates FQHC look-alikes based on the recommendation of HRSA. When CMS receives a recommendation from HRSA, CMS notifies the State Medicaid agency of a pending application for FQHC designation and provides the state with an opportunity to comment on the application. Once all issues are addressed, CMS notifies HRSA and the State Medicaid agency that the application has been approved and HRSA notifies the center of the approval. In CY 2004, CMS approved 26 applications. Currently, six applications are under review.

Medicaid Covers FQHCs as a Mandatory Benefit

As mentioned earlier, FQHCs provide a package of primary and preventive care services to Medicaid beneficiaries. These services include physician, nurse practitioner, physician assistant, clinical psychologist and clinical social worker, plus any other ambulatory service that is covered in the state plan. FQHCs are paid under the Medicaid program for services on a per visit basis, rather than billing separately for each service provided when a patient visits a health center.

The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) established a prospective payment system for FQHCs. This system, which has been in place since January 2001, replaced the previous cost-based reimbursement system for health centers under Medicaid. The prospective payment system establishes a per visit payment rate for each FQHC in advance. The 2001 payment rate was based on the average of each FQHC's reasonable costs per visit in FY 1999 and FY 2000. Since FY 2002, payments made under this system have been adjusted annually for inflation using the Medicare Economic Index. Payments also are adjusted based on increases or decreases in change in scope of services provided.

States have the option of using an alternative payment mechanism, provided the payment rate is not lower than what would be paid under the new PPS. For example, states may opt to establish an alternative PPS or retain the original cost-based reimbursement system. CMS must review and approve the payment system; and, the FQHC must agree to the alternative methodology. Most states are using the PPS option established under BIPA, while 15 states opted to use cost-based reimbursement and eight states elected to implement an alternative PPS to pay at least a portion of their FQHC costs.

In addition, states are required to make supplemental payments to FQHCs that provide care to Medicaid beneficiaries enrolled in a managed care plan to cover the difference between the rates paid by managed care plans and the FQHC's prospective payment rate. FQHCs receive the same payment rate from managed care plans that the plans pay to other providers for similar services. This supplemental payment provision was added as

an incentive to FQHCs to participate in managed care plans. FQHCs are guaranteed a PPS rate as a minimum to participate in a managed care plan.

Medicare Payments Based on Reasonable Costs

FQHC services also are available to Medicare beneficiaries under Part B. The Medicare FQHC benefit provides coverage for a full range of primary care services (and services incident thereto) including physician, physician assistant, nurse practitioner, and certain other non-physician practitioner services such as clinical social worker and clinical psychologist services. The benefit also covers a range of preventive services as well as pneumococal and influenza vaccines. In CY 2003, almost 900,000 Medicare beneficiaries received care at a section 330-funded FQHC.

Medicare pays FQHCs an all-inclusive per visit payment amount, based on reasonable costs as determined through the filing of its Medicare cost report. The FQHC's all-inclusive per visit payment amount is subject to one of two upper payment limits (UPL), depending upon whether the FQHC is located in an urban or rural area. In CY 2005, the UPL is $109.88 for urban centers and $94.48 for rural centers. In FY 2004, Medicare spent about $265 million on services provided by FQHCs. To ensure payment rates are appropriate, CMS and HRSA are jointly evaluating the current UPLs for Medicare FQHC services.

In addition, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) establishes a wrap-around payment in Medicare, similar to the supplemental payment in Medicaid. CMS will pay FQHCs the difference between what a Medicare Advantage health care plan pays the FQHC, and the reasonable cost payments the FQHC otherwise would receive under Medicare fee-for-service. Medicare Advantage plans must pay FQHCs the same levels and amounts they pay other providers for similar services. This provision becomes effective for services provided on or after January 1, 2006 and contract years beginning on or after January 1, 2006.

Ensuring FQHCs Participate in the Medicare Prescription Drug Program

HRSA and CMS have been working closely together on efforts to implement the new prescription drug benefit under Medicare Part D, and will be working to make sure health centers are a key part of that effort, particularly with respect to outreach and education of low-income Medicare beneficiaries who are eligible for the low-income subsidy program and will be eligible for a comprehensive drug benefit with minimal copayments. Also, health centers with pharmacies will be able to participate in prescription drug coverage plans and Medicare Health Plans with prescription drug coverage. In addition, the final rule implementing the MMA provides that prescription drug coverage plans and Medicare Health Plans may count FQHC pharmacies in meeting the MMA pharmacy access standards, and this will give these plans incentives to include FQHC pharmacies in their plan networks.

Conclusion

CHCs are an important part of the Medicare and Medicaid networks of providers. The substantial growth in expenditures reflects the increase in access to care at CHCs through the President's initiative as well as partnerships that have been formed over the years between HRSA, CMS, the Centers, the states, and managed care organizations.

Thank you again for this opportunity and I look forward to answering any questions you might have.